



Program Review Form

To ask Healthy Families to review and change a decision

Instructions

Use this form if you do not agree with a decision Healthy Families made about you or your family. You may ask Healthy Families to change the decision. Fill out the form and mail it to Healthy Families so that we receive it within 60 days of the decision. Cross out and correct any information that is wrong.

Questions?

If you have any questions about the form, call Healthy Families: **1-866-848-9166**, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.

☐ **Check this box if you are sending new income or other new papers with the form.**

A. Information about you.

B. Information about the person or persons whose coverage has ended.

C. Reason for review.

You *must* answer questions 1 through 4 below. You can answer 5 if you want to. Use extra paper if you need more space to write.

1. What is the decision you would like us to review?

Tell us about the decision you would like us to review. Or, include a copy of the letter you got from Healthy Families that talks about the decision.

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2. Why do you think our decision is wrong?

Write your reason below. Or, check the boxes below. Check as many as you wish.

- | | |
|--|---|
| <input type="checkbox"/> Income was figured wrong | <input type="checkbox"/> Payment was made |
| <input type="checkbox"/> Member is not on no-cost Medi-Cal | <input type="checkbox"/> I think decision violates Healthy Families policy or law (explain below) |
| <input type="checkbox"/> Sent papers that were asked for (tell us below when you mailed or faxed the papers) | <input type="checkbox"/> Other (explain below) |

3. What would you like us to do?

- | | |
|--|--|
| <input type="checkbox"/> Keep family members in Healthy Families | <input type="checkbox"/> Other (explain below) |
|--|--|

4. What else would you like us to know?

Is there any other information you think would help us review our decision? Write the information or send other papers that will help us understand.

D. Sign the form and send it to us within 60 days of the decision.

Signature: _____ **Date:** _____

Mail the form and other papers to:

**Healthy Families
Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005**

Or, you can fax the form and papers to:

Fax: 1-866-848-4974 The call is free.

Write your Family Member Number on each paper you send. **Your Family Member Number is:**

E. Permission to share information with the following person:

I give permission to Healthy Families to share information about what is happening with my review with:

Name: _____

➡ **Signature:** _____ **Date:** _____